

**Gazewood & Weiner**  
**Attorneys at Law, P.C.**  
1008 16<sup>th</sup> Ave. Ste. 200  
Fairbanks, Alaska 99701  
(907) 452-5196 or FAX (907) 456-7058  
(907) 452-4255 or FAX (907) 456-1480  
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FACSIMILE TRANSMITTAL COVER SHEET

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IMPORTANT MESSAGE

This message is intended only for the use of the individual or entity to which it is addressed, and may contain information that is privileged, confidential and exempt from disclosure under applicable law. If the reader of this message is not the intended recipient, or the employee or agent responsible for delivering the message to the intended recipient, you are hereby notified that any dissemination, distribution or copying of this communication is in error. Please notify us immediately by telephone, and return the original message to us at the above address via the US Postal Service. Thank you.

DATE:

05 Jul 11

TIME:

5:09

AM/PM (PM)

TO:

Ian Cunningham - Director of Contracting - Qualis Health

FAX NUMBER:

206-368-2419

REPLY REQUESTED: ☒ YES

☐ NO

NUMBER OF PAGES TO FOLLOW (Cover page plus):

4

MESSAGE:

Fax consists of July 5, 2011 Letter re Request for Records,  
May 11, 2010 Letter of Qualis Health denying precertification,  
Signed Release of Information

SENDER'S NAME:

Yauna Taylor

IF YOU DO NOT RECEIVE ALL PAGES OF THIS TRANSMITTAL, CALL THE ABOVE SENDER IMMEDIATELY AT (907) 452-4255.

# GAZEWOOD & WEINER

Attorneys at Law, P.C.

1008 16<sup>th</sup> Avenue, Suite 200  
Fairbanks, Alaska 99701  
Telephone: (907) 452-5196  
Facsimile: (907) 456-7058

Jason A. Gazewood  
Jason A. Weiner

JB Brainerd  
Kristin Farleigh

## VIA FACSIMILE ONLY (206) 368-2419

July 5, 2011

Qualis Health  
PO Box 33400  
Seattle, WA 98133-0400

**ATTENTION: JAN CUNNINGHAM – Director of Contracting**

Dear Jan:

This letter is to follow up with our telephone conversation last week regarding records of Justin Olsen. Mr. Olsen has retained Jason A. Weiner to represent him regarding the denial of his medical benefits.


Specifically, we are requesting all documents used during and pertaining to Qualis Health's appeal review and subsequent May 11, 2010 denial. (See attached letter of Qualis Health, denying precertification).

I have attached the Request for Authorization that you requested in order to release these records to our office.

If you need anything else from us, please do not hesitate to contact me at (907) 452-5196 or by email at [ytaylor@fairbanksaklaw.com](mailto:ytaylor@fairbanksaklaw.com).

Thank you for your prompt attention in this matter.

Sincerely,

  
Yanna Taylor  
Paralegal



PO Box 33400  
Seattle WA 98133-0400  
[www.qualishealth.org](http://www.qualishealth.org)



# CONFIDENTIAL AND ADVISORY

## ALASKA TEAMSTER-EMPLOYEE WELFARE TRUST UPHELD APPEAL NOTICE

May 11, 2010

JUSTIN OLSEN  
1075 CLOVERLEAF DR  
NORTH POLE, AK 99705

Date of Birth: 06/17/1982  
Case Number: 26502191  
Subscriber Name: Justin Olsen

Appeal Type: Standard  
Insurance ID: 959103757

Physician: Larry Wolford, M.D.  
Admit Date: 6/2/2010

Facility: Baylor University Medical Center  
Discharge Date:

Diagnosis: 714.30 POLYARTICULAR JUVENILE RHEUMATOID ARTHRITIS, CHRONIC OR UNSPECIFIED

Status From To  
Deny 6/2/2010 6/5/2010

Procedure  
21243 ARTHROPLASTY, TEMPOROMANDIBULAR JOINT, WITH PROSTHETIC JOINT REPLACEMENT

In order to promote high quality health care, Qualis Health has been authorized by your healthcare plan to pre-certify inpatient admissions, surgical procedures and select outpatient services. Qualis Health's function is to determine medical necessity.

**It is your responsibility to review your benefit plan booklet to determine if the recommended treatment/procedure(s) is covered under your plan and to verify your eligibility.** In the event you receive treatment and/or services outside the Plan's Preferred Provider network, by using a *non-Preferred Provider*, you will pay significantly more out-of-pocket. Questions regarding the benefit provisions of your plan should be directed to your health plan's Customer Service at 800-478-4450.

Qualis Health performed the initial review of the above referenced health care service(s). The appeal review was completed by a Qualis Health medical peer consultant with the same or similar specialty as the attending physician. **The decision after appeal is to uphold the original non-certification.** This determination is based on the following: After review of the clinical information submitted, our Oromaxillofacial peer consultant has advised that the proposed procedure cannot be approved at this time. Symptoms described do not indicate need for total joint replacement which would have a high risk of not addressing patients complaint of pain. Additional clinical rationale used in making the appeal decision will be provided, in writing, upon request.

This notification does not prohibit you from being admitted to or remaining in the facility, but it does mean that Qualis Health will inform your healthcare claims payer that we cannot certify the requested health care services. The final decision for continued medical treatment is between you and your physician. Without Qualis Health approval, benefits may be reduced or charges disallowed.

If you have any questions regarding this notification, please contact Qualis Health at 1-800-783-8606.

Sincerely,

A handwritten signature in black ink that reads "Eric M. Wall". The signature is stylized with a large, sweeping "E" and a cursive "M".

Eric M. Wall, MD, MPH  
Senior Medical Director

cc:      Attending Provider  
         Claims Payer  
         Facility UM Department  
         Facility Billing Department  
         Qualis Health File

**Medical Authorization to Disclose Health Information**  
**(Medical Records Release Form) - HIPAA Patient Authorization to Use/Disclose**

**TO:** Qualis Health

I, Justin Olsen, DOB: 6/17/1982, SSN: 574-72-3179 hereby authorize the above provider, to release confidential health information and documents to:

Gazewood & Weiner P.C.  
 1008 16<sup>th</sup> Avenue  
 Fairbanks, Alaska 99501

or any person employed on his behalf. This authorization is for legal purposes.

I specifically authorize the disclosure of the following health information and records:

- |                                                                                                             |                                                                 |
|-------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|
| <input checked="" type="checkbox"/> Entire medical records in your possession (all information), including: |                                                                 |
| <input checked="" type="checkbox"/> Billing records                                                         | <input checked="" type="checkbox"/> Radiology & Lab Reports     |
| <input checked="" type="checkbox"/> Admission/Intake Summary                                                | <input checked="" type="checkbox"/> Treatment Plan              |
| <input checked="" type="checkbox"/> Discharge Summary                                                       | <input checked="" type="checkbox"/> Medication/Pharmacy Records |
| <input checked="" type="checkbox"/> Chart Notes                                                             | <input checked="" type="checkbox"/> Exchange of information     |
| <input checked="" type="checkbox"/> History and Physicals                                                   | <input checked="" type="checkbox"/> Procedure Notes             |
| <input checked="" type="checkbox"/> Information relied upon during and related to precertification reviews  |                                                                 |

I. JLO (initial) I acknowledge, and hereby consent to such, that the release information may contain alcohol, drug abuse, psychiatric, psychosocial, HIV testing, HIV results or AIDS information.

II. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or eligibility for treatment. I may inspect or copy records disclosed with this authorization.

III. I understand that if the person or entity receiving this information is not a health care provider covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by the HIPAA Privacy regulations. However, the recipient may be prohibited from disclosing my health information under other applicable state or federal laws and regulations.

IV. I understand I have a right to revoke this authorization in writing at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to **GAZEWOOD & WEINER P.C.**, whose address is listed above. I understand the revocation will not apply to information that has already been released in response to this authorization.

V. I understand that under Alaska law, **GAZEWOOD & WEINER P.C.**, or persons employed on his behalf, is permitted to discuss my medical condition (including contents of medical, psychological, or psychotherapy records) with my physicians. [*Langdon v. Champion*, 745 P.2d 1371, 1374 (Alaska 1987)]. It is within the discretion of my physician whether the physician wishes to participate in such discussions.

VI. This authorization expires 360 days (12 months) from the signature date below.

Signature: Justin Olsen Date: 5 July 2011  
 Address: 1075 Cleveland Dr North Pole AK 99705 Phone Number: (907) 590-6569

SUBSCRIBED & SWORN TO BEFORE ME this 3<sup>rd</sup> day of July, 2011.

**Jauna Taylor**  
 Notary Public  
 State of Alaska  
 Commission No. 112846  
 My Commission Expires  
 February 5, 2013

Notary Public in and for Alaska  
 My Commission Expires: 2/5/2013

TRANSMISSION VERIFICATION REPORT

TIME : 07/05/2011 17:11  
NAME :  
FAX :  
TEL :  
SER.# : D0J384668

DATE, TIME	07/05 17:10
FAX NO./NAME	12063682419-02826
DURATION	00:00:49
PAGE(S)	05
RESULT	OK
MODE	STANDARD
	ECM